STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 19,796
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision by the Department for Children and Families, Office of Vermont Health Access (OVHA) denying prior approval under Medicaid for genital gender reassignment surgery and related procedures. The issue at this time is whether the petitioner's appeal should be dismissed as moot. This matter has had a long and tortuous procedural history. The following description of that history is taken from the case record to date submitted by the parties.

DISCUSSION

In May 2005 the petitioner submitted a request under M108 for coverage for electrolysis for her face and neck, which the provider of that service indicated was "necessary in order for her to achieve a female identity". When the petitioner learned the Department had denied the request she requested a fair hearing, which the Board received on July 8, 2005.

An initial hearing was held on July 28, 2005, at which time the matter was continued by the parties' agreement to allow the petitioner to submit additional medical evidence and for the Department to issue a revised decision based on that evidence. On August 25, 2005 the petitioner submitted a report from her local treating physician stating his support for medical treatment of the petitioner's "transgenderism". On September 15, 2005 the petitioner submitted letters from surgeons in Boston and Montreal regarding proposed treatments, including surgery.

At a hearing held on September 22, 2005 the matter was continued to allow the case to be referred to a consulting psychologist with expertise in gender reassignment issues. On October 6, 2005 the psychologist submitted a report to OVHA finding that the petitioner met the criteria for coverage.

On December 14, 2005 the Department sent the petitioner a letter approving "coverage of treatment and surgery necessary for sexual reassignment". The letter instructed the petitioner's providers to submit a plan of care with specific prior approval requests directly to OVHA's medical director.

On January 4, 2006 the Department sent the petitioner a letter advising her that Medicaid regulations did not allow coverage for doctors outside the United States and that she should advise OVHA when she located a physician in the U.S. The letter also advised the petitioner to select and identify a doctor "who will manage the gender reassignment process".

On January 31, 2006 OVHA received a request from a surgeon in Boston for prior approval of "facial feminization surgery", which was described as "making major adjustments to her forehead, nose, jaw, chin, scalp, brow, eyes, lips, trachea and cheeks to feminize the face and remove any visible masculine facial traits". On February 22, 2006 OVHA denied the request after determining that it was cosmetic and not medically necessary.[1]

On February 24, 2006, the Department received a release from the petitioner authorizing representation by a health care ombudsman.

Another hearing was held on March 2, 2006. At that time the parties reported that the remaining issues regarding coverage involved procedures the Department considered

[1] There is no indication in the record that the need for such surgery had been specifically identified or contemplated in the Department's earlier approval of "treatment and surgery necessary for gender reassignment".

cosmetic, i.e., facial feminization surgery and electrolysis. In addition, the Department identified the lack of medical qualifications for the electroysist, and advised the petitioner to consider laser surgery as an alternative. The hearing officer instructed the Department to provide further rationale for its denial of these procedures.

On April 12, 2006, following the submission by the petitioner of further medical opinion regarding the need for facial surgery and electrolysis, the Department sent the petitioner's advocate a letter reiterating and emphasizing the Department's position that the petitioner needed to designate a Medicaid enrolled physician to coordinate her treatment, and detailing the information necessary to be submitted by providers in order to obtain prior approval.

Requests by the petitioner's legal representatives for continuances of the fair hearing in order to submit additional information were granted on April 21 and May 16, 2006. A status conference was scheduled for June 23, 2006 and an evidentiary hearing for June 27, 2006. However, no further evidence was submitted, and on June 12, 2006 the Board received a notice from the petitioner's legal representative withdrawing the ombudsman office's representation of the petitioner.

In the meantime, however, on May 26, 2006 the Board received a separate request for hearing for the petitioner regarding a disability decision. The Board assigned Docket No. 20,344 to this new appeal. On June 14, 2006 Vermont Legal Aid notified the Board that it was representing the petitioner in both cases, and requested that both matters be continued for the submission of further medical evidence. A hearing was scheduled for July 21, 2006.

On June 14, 2006 the petitioner sent the Department a letter stating that she understood, and was "in the process of complying", with the "care plan for coordinated services" from her doctors. On June 28, 2006 the Board received a request for an open-ended continuance from the petitioner's Legal Aid representative until she could obtain needed medical information from the petitioner's providers. On June 29, 2006 the Board sent the parties a written notice that the matter was continued and advising the parties to keep the Board informed as to the status of the case.

The Board then heard nothing from the parties on this case for several months.[2] On May 8, 2007 the Board sent a notice to the petitioner's legal representative advising her

[2] During this period the Board was informed that the petitioner had been found disabled, and Fair Hearing No. 20,344 was withdrawn.

that the instant matter would be marked "withdrawn" unless she advised the Board otherwise within ten days. On May 15, 2007 the petitioner's representative notified the Board that she was no longer representing the petitioner in this matter. On May 18, 2007 the Board sent the petitioner a notice advising her to notify the Board immediately if she wished to pursue her appeal. On May 31, 2007 the Board received a letter from the petitioner advising that the matter was not resolved. The Board then scheduled a telephone status conference on July 17, 2007.

On the morning of the scheduled status conference the Department's attorney notified the Board that the petitioner had requested a continuance due to storm damage in her home. The Board rescheduled the matter on August 17, 2007.

On August 17, 2007 the petitioner did not answer her phone at the time of the status conference. However, the petitioner met with the Department's attorney after the scheduled time, gave him some additional documents she had brought with her, and requested a further continuance for the Department to consider those documents.

A telephone status conference was held on September 21, 2007. The Department informed the petitioner and the Board that it still had not received a plan of care from a

supervising doctor. The petitioner maintained that her doctor had submitted such a plan. The hearing officer directed the Department to provide him and the petitioner with the entire written record in the matter and a rationale stating its reasons for not approving all aspects of the petitioner's gender reassignment procedures.

On October 23, 2007 the Department submitted a detailed written filing of the history of the case along with all the medical evidence and correspondence it had received in connection with the petitioner's claim. In its filing the Department represented that it had contacted the petitioner's treating physician by phone in late August 2007 to advise him of the need for a plan of care for the petitioner and to offer to assist him in its preparation. The Department represented that to date no such plan has been submitted.

At a telephone status conference held on October 29, 2007 the hearing officer gave the petitioner two weeks to file any written response to the Department's submission, which the petitioner failed to do.

On December 13, 2007, the hearing officer had completed a recommended decision to the Board that the matter be dismissed based on the petitioner's failure to make progress in her appeal. However, on that same date, before that

Recommendation was mailed to the Board and the parties, the petitioner called to inform the Board that she had obtained the representation of the Vermont Health Care Ombudsman Office, and she requested an additional month to gather additional medical evidence. The matter was reset for a telephone status conference on January 11, 2008.

On January 10, 2008, the Board received a written notice of appearance from a health care advocate in the Ombudsman Office. At the status conference on January 11, 2008, the parties informed the hearing officer that the Department was in the process of considering a plan of care that had recently been submitted in the petitioner's behalf.

Hearing nothing from the parties for several more months, the hearing officer scheduled another status conference on May 14, 2008. At that conference the parties represented that the petitioner had recently been found eligible for Social Security and Medicare based on disability, and that the medical services in question would have to be submitted for Medicare approval prior to consideration by the Department under Medicaid (although the plan of care finally submitted by the Department had apparently been approved). The parties also represented that the petitioner's receipt of Social Security benefits had

placed her over income for Medicaid and that effective March 1, 2008 the petitioner had been given a Medicaid spenddown. The petitioner's advocate represented that he did not see any remaining issue as to Medicaid coverage, and that he would recommend to the petitioner that she withdraw her request for hearing.

After the Board sent the parties a letter asking to confirm that the matter was settled, the petitioner informed the Board that she had "released" her advocate and that she would not withdraw her hearing until issues regarding her "spenddown" had been resolved.

At a status conference held on June 11, 2008, the hearing officer advised the parties that he would decide the issues regarding coverage, and would address any issues that have arisen since March 1, 2008 regarding the petitioner's spenddown in a separate decision.

Since that time the petitioner has submitted extensive documents and written arguments regarding her spenddown. The Board has assigned a new docket number to that case (N-06/08-295) and it is scheduled for hearing in mid-July

ODER

The petitioner's appeal is dismissed as moot.

REASONS

The Medicaid regulations include provisions allowing the Department to require a "patient's plan of care" as necessary "supporting information" for prior authorization. W.A.M. § M106.3. The hearing officer, by allowing the petitioner and her advocates extraordinary leeway and by not more closely monitoring the prosecution of this appeal, accepts much of the responsibility for the amount of time it has remained open without resolution. There is no question, however, that the Department's position regarding the petitioner's need for a supervised medical plan of care was made clear at the outset. In this case the petitioner was given well over two years, with the assistance of three separate legal representatives, as well as direct personal contact and offers of assistance by the Department to her physician, until she was able to submit such a plan from her doctors. Neither her doctors nor her legal representatives ever indicated or argued that the Department's request for such a plan as a precondition of prior approval under Medicaid was unreasonable or unwarranted, either as a matter of law or medical judgement.

Not surprisingly, the petitioner's financial status and her eligibility for other programs have changed during the

pendency of this appeal. Although she now has an approved plan of care for Medicaid, any specific requests for coverage will now have to be submitted to Medicare in the first instance. Medicare has a completely separate coverage and appeal process, not subject to either Department or Human Services Board jurisdiction.

The petitioner's alleged problems regarding her Medicaid spenddown have arisen only since March 1, 2008, after she began receiving Social Security benefits. Those concerns are the subject of another fair hearing that is still pending. At this time, the petitioner has not articulated, nor can the hearing officer discern, any unresolved issue that remains relative to the petitioner's request for hearing in this matter submitted in July 2005. Accordingly, the petitioner's appeal must be dismissed.

# # #